HEBRON PEDIATRICS
Patient Registration Form

Patient Name: _____ Sex: ____ Date of Birth: _____

Street Address: _____ Apt No: _____

City: _____ State: _____ Zip Code: _____

Race (Please Circle): American Indian/Alaska Native Asian African-American White Other

Ethnicity (Please Circle): Hispanic Non-Hispanic

Mother/Guardian Name: _____

Date of Birth: _____

Phone Number: _____Consent to receive text message: Yes No

Email: _____Consent for Patient Portal: Yes No

If address is same as above, check here ☐

Street Address (If different): _____ Apt No:_____

City: _____ State: _____ Zip Code: _____

Father's Name: _____

Date of Birth: _____

Phone Number: _____ Consent to receive text message: Yes No

Email: _____Consent for Patient Portal: Yes No

If address is same as above, check here ☐

Street Address (If different): _____ Apt No:_____

City: _____ State: _____ Zip Code: _____

Primary Insurance Name: _____

Name of Policy Holder: _____

ID Number: _____ Group Number: _____

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Secondary Insurance (If applicable): _____

Name of Policy Holder: _____

ID Number: _____ Group Number: _____

Referred By (Please circle): Friend Doctor School Google Insurance Other_____

☐ By checking this box, you agree to receive recurring messages from Hebron Pediatrics, Reply STOP to Opt out. Reply HELP for help. Message frequency varies. Message and data rates may apply. Carriers are not liable for delayed or undelivered messages.

I warrant that I am the responsible party for making the medical decisions for the child represented in this medical record. I hereby give consent for Hebron Pediatrics staff to treat my child. I acknowledge that payment is due at the time of service, unless other arrangements have been made. I assume financial responsibility for any all healthcare services provided to this patient.

_____ _____

Signature of Parent/Legal Guardian/Guarantor Date

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Office Policy

Statement of Financial Obligation

All payments are expected at the time of service.
This office is contracted with many different insurance plans. We will be happy to file your insurance claims, however you will be expected to pay your co-payment, deductible and/or co-insurance due at each visit. We accept cash or credit/debit card. Account balances past 60 days will incur a $25 monthly charge until it is paid in full.

Primary Care Physician

If you are required by your insurance company to select a primary care physician, this must be done prior to your child's appointment. Your health insurance is a contract between you and your health insurance company. You are financially responsible for any non-covered services.

Vaccination

Unless there is a medical contraindication, we require your child to be immunized with all the ACIP recommended vaccines. Failure to do so will result in discharge from the practice.

Private Pay Patients

If you do not have insurance, payment is due at the time services are rendered.

Statement of Benefit Obligation

All patients are expected to provide our office with current insurance information and to understand their benefits. For the convenience of our patients, our provider participates in a variety of managed care plans. Ultimately, the patient is responsible for understanding their benefits and providing our office with current information so that we can handle this paperwork on their behalf in a timely manner.

Medical Records / Shot records/ School Forms

Our office has 30 business days to release your child's medical records. Please give our office 5 business days for your school forms, camp forms, and sports physical forms. Please note we do not provide printed copies of medical records except vaccine record.
I have read, understood and will comply with the above policies. I understand that I am responsible for the charges occurred by my child/children regardless of insurance benefits. If by using the information I have provided today or on previous occasions, Hebron Pediatrics is unable to collect from my insurance company, I accept full responsibility for the payment of my bills.

Signature of Parent/Legal Guardian/Guarantor: _____

Date: _____

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Consent for Use and Disclosure of Health Information

I hereby permit Hebron Pediatrics to release and furnish all medical and financial data related to the patient that may be necessary now or in the future for the purpose of treatment, payment or healthcare operation to assist with, aid in, or facilitate the collection of data for purpose of utilization review, quality assurance or medical outcomes evaluation process. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, Medicare/Medicaid or other governmental or third-party payers or any organization contracting with any of the above entities to perform such functions.

The Notice of Privacy Practices provided by Hebron Pediatrics provided complete description of how my Personal Health Information may be used and disclosed.

You have the right to request that this office restrict use and disclosure of your health information, however this office is not required to agree to requested restriction. Your treatment at this office is conditional upon signing this consent.

Signature of Parent/Legal Guardian/Guarantor: _____

Date: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Phone: _____

Previous Doctor/Facility Name: _____

Phone: _____ Fax _____

Address: _____ City/State/Zip: _____

I hereby authorize the release of the following records to:

Facility Name: Hebron Pediatrics **Facility Phone: 972-695-9630** **Fax: 972-694-0000**

Facility Address: 3020 E Hebron Pkwy, Ste 300, Carrollton, TX 75010

The information requested is as follows:

- ☐ Immunization Records
- ☐ Other: _____

Parent/Guardian Signature: _____

Parent/Guardian Name: _____

Date: _____